PATIENT REGISTRATION AND MEDICAL HISTORY FORM

FOUNDATION ENDODONTICS

Please Circle: Ms. Mr. Mrs. Dr. Other: _____

_____ _____ _____ _____
First Name Last Name M.I. Name Preference

_____ _____ _____ _____
Address City State Zip

_____ _____ _____
Cell # Home # Email

_____ _____ _____ _____
Date of Birth Gender SSN # Occupation

_____ _____
Employer Name Employer Address

_____
General Dentist/Referring Dentist

_____ _____
Family Physician Date of Last Physical Exam

_____ _____ _____
Emergency Contact Cell # Relationship

Do you have or have you had any of the following?

☐ Artificial Heart Valve	☐ Heart Surgery	☐ High Blood Pressure	☐ Hepatitis	☐ Stomach Ulcers
☐ Congenital Heart Disease	☐ Heart Pacemaker	☐ Diabetes	☐ HIV	☐ Bleeding Disorder
☐ Infective Endocarditis	☐ Heart Attack	☐ Thyroid Disorder	☐ Tuberculosis	☐ Dialysis
☐ Knee/Hip Replacement	☐ Heart Murmur	☐ Asthma	☐ Dialysis	☐ Epilepsy

Any **other** diseases or problems? _____

Have you ever taken **Bisphosphonates**? _____ (i.e. Fosamax, Aredia, Zometa, Actonel, Boniva, Skelid, Didronel, Bonefos Ostec)

Have you had an unusual reaction/allergy to **LATEX**, **ANESTHETICS**, or drugs as **PENICILLIN**, **CLINDAMYCIN**, **NOVOCAINE**, **IBUPROFEN**, **ASPIRIN** or any other medications? _____

Have you taken **Aspirin**, **Ibuprofen** or **Tylenol** in the last 24 hours? ☐ Yes ☐ No

Women Only: **Pregnant** or **Possibility of Pregnancy**? ☐ Yes ☐ No

Please list any **medications** you are taking at present and the **reason** for each:

_____

_____

_____

X_____ _____
Signature of Patient/Guardian **Date**